

**SOUTH CAROLINA STATE BUDGET AND CONTROL BOARD
EMPLOYEE INSURANCE PROGRAM (EIP)
SURVIVOR NOTICE OF ELECTION**

S
SEE INSTRUCTIONS
IF COMPLETING BY HAND
USE BLACK INK

ELIG.	Select ONE or BOTH: <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Surviving Dependent Children	Are you an active employee of a state agency, public school district or participating county? <input type="checkbox"/> YES <input type="checkbox"/> NO	Information Concerning Deceased Name _____ SSN _____ Date of Death _____		Killed in line of duty? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Verification of eligibility (required of survivors from entities other than state agencies and school districts) Benefits Administrator Signature _____ Employer ID _____				
ACTION	Select ONE of the Following: <input type="checkbox"/> New Subscriber <input type="checkbox"/> Termination <input type="checkbox"/> Address Change <input type="checkbox"/> Change (Specify) _____ Date of Occurrence _____ SSN Change - Incorrect # _____ Name Change - Prior Name _____ (Attach Copy of Social Security Card)				EIP USE ONLY Employer ID _____ Effective Date _____ Group ID# _____
ENROLLEE INFO	1. Social Security Number _____		2. Last Name _____		3. Suffix _____
	4. First Name _____		5. M.I. _____		6. Date of Birth MM/DD/YYYY _____
ENROLLEE INFO	7. Sex <input type="checkbox"/> M <input type="checkbox"/> F	8. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated		9. Home Phone # () _____	
	10. E-mail Address _____		11. Mailing Address _____		12. Apt. _____
ENROLLEE INFO	13. City _____		14. State _____		15. Zip Code _____
	16. County Code _____				
COVERAGE	It is your responsibility to select the appropriate insurance coverage. See the benefits options before making your selection. Select one health plan and dental plan(s). To refuse coverage, mark "REFUSE."				
	17. HEALTH PLAN (Refuse or select one plan and one category) PLAN <input type="checkbox"/> Standard <input type="checkbox"/> HMO _____ <input type="checkbox"/> Refuse <input type="checkbox"/> Savings (Non-Medicare) <input type="checkbox"/> Medicare Supplement <i>Name of HMO</i> _____ CATEGORY <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Surviving Spouse/Child(ren) <input type="checkbox"/> Child(ren) Only		18. STATE DENTAL PLAN (Select One) <input type="checkbox"/> Refuse <input type="checkbox"/> Child(ren) Only <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Surviving Spouse/Child(ren)		19. DENTAL PLUS (Select One) <input type="checkbox"/> Yes <input type="checkbox"/> Refuse (You must be enrolled in the State Dental Plan to elect Dental Plus. If no election is indicated for Dental Plus, you will not be enrolled for this coverage.)
MEDICARE AND OTHER COVERAGE	LIST BELOW, YOURSELF AND ANY OTHER PERSONS TO BE COVERED WHO ARE ELIGIBLE FOR PART A AND/OR PART B OF MEDICARE.				
	20. NAME _____		MEDICARE# _____		ELIGIBLE DUE TO <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease
MEDICARE AND OTHER COVERAGE	EFFECTIVE DATE PART A MM/DD/YYYY _____		PART B MM/DD/YYYY _____		
	Do you or any of your dependents have other group health coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO Does this coverage include pharmacy benefits? <input type="checkbox"/> YES <input type="checkbox"/> NO If you and/or your dependents have had other coverage with another carrier within 62 days of this request, please attach a copy of your certificate of health coverage. This will ensure proper credit for any pre-existing conditions, if applicable.				
MEDICARE AND OTHER COVERAGE	21. DEPENDENT NAME _____		INSURANCE COMPANY _____		POLICY HOLDER DATE OF BIRTH _____
	EFFECTIVE DATE OF POLICY _____		TERMINATION DATE _____		
DEPENDENTS	LIST ALL CHILDREN TO BE COVERED UNDER HEALTH AND/OR DENTAL. If they are not listed, they will not be covered. In order for children age 19 through 24 to be considered eligible for coverage, documentation must be provided to verify the dependent is a full-time student or incapacitated.				
	Add (A) or Delete (D)	22. Dependent SSN# _____	Last Name _____	First Name _____	SEX M/F _____
DEPENDENTS	Relationship _____		Date of Birth MM/DD/YYYY _____		Complete Below If Child is Over 19 <input type="checkbox"/> Full-time student <input type="checkbox"/> Incapacitated
	Child		Child		<input type="checkbox"/> Full-time student <input type="checkbox"/> Incapacitated
DEPENDENTS	Child		Child		<input type="checkbox"/> Full-time student <input type="checkbox"/> Incapacitated
	Child		Child		<input type="checkbox"/> Full-time student <input type="checkbox"/> Incapacitated
CERTIFICATION & AUTHORIZATION	23. CERTIFICATION: I have read this NOE and made authorizations herein and selected the coverage noted. I have provided Social Security numbers and documentation establishing my dependent(s)' eligibility for the Plan(s) selected. I understand that unless otherwise provided in the Plan, I may cancel coverage for me or my dependent(s) only during an open enrollment period (every two years). Should I refuse any coverage or fail to enroll all eligible dependents when first eligible, I and/or all eligible dependents may only enroll during an open enrollment period (every two years) unless otherwise provided by the Plan. I understand that the state reserves the right to alter benefits or premiums at any time to preserve the financial stability of the Plan and agree that all selected plans will not be effective unless and until the NOE is approved. I understand that remarriage will end my eligibility for coverage but will not affect eligibility for eligible dependent child(ren). AUTHORIZATION: I understand that it is my sole responsibility to pay all required				
	premiums for all plans selected. Failure to pay the required premiums by the due dates will result in cancellation of coverage. I authorize EIP to deduct my insurance premiums from my retirement income if sufficient. I authorize any healthcare provider, prescription drug dispenser and claims administrator to release any information necessary to evaluate, administer and process claims for any benefits. DISCLAIMER: THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.				
CERTIFICATION & AUTHORIZATION	Enrollee Signature _____ Date _____				

SURVIVOR NOTICE OF ELECTION FORM INSTRUCTIONS

ELIGIBILITY: The spouse and dependent children of a deceased covered employee/retiree, who are covered at the time of the death of employee/retiree, can continue the same coverage from the date of death. Eligible dependents who are not covered at the time of death may enroll in a health plan and in the dental plan(s) only during a designated enrollment period. Indicate if you are a surviving spouse and/or surviving dependent child(ren) and if you are an active employee of a state agency, public school district or other participating entity. Complete information concerning deceased employee or retiree.

ACTION: If you are enrolling as a survivor for the first time, check "New Subscriber." If you are already enrolled as a survivor and are making a change, check "Change" and indicate the type of change and date of occurrence. If you wish to terminate your coverage, check "Termination."

ENROLLEE INFORMATION: **Blocks 1-16** must be completed for all transactions including termination. Enrollee information should be for the surviving spouse, unless coverage is only for dependent child(ren). If coverage is only for dependent child(ren), enrollee information should be for the youngest child or, if applicable, for a child covered under Medicare; additional children should be indicated as dependents in **block 22**. In **block 16**, indicate the county code of your mailing address.

LIST OF COUNTY CODES:

01 Abbeville	11 Cherokee	21 Florence	31 Lee	41 Saluda
02 Aiken	12 Chester	22 Georgetown	32 Lexington	42 Spartanburg
03 Allendale	13 Chesterfield	23 Greenville	33 McCormick	43 Sumter
04 Anderson	14 Clarendon	24 Greenwood	34 Marion	44 Union
05 Bamberg	15 Colleton	25 Hampton	35 Marlboro	45 Williamsburg
06 Barnwell	16 Darlington	26 Horry	36 Newberry	46 York
07 Beaufort	17 Dillon	27 Jasper	37 Oconee	99 Out of S.C.
08 Berkeley	18 Dorchester	28 Kershaw	38 Orangeburg	
09 Calhoun	19 Edgefield	29 Lancaster	39 Pickens	
10 Charleston	20 Fairfield	30 Laurens	40 Richland	

COVERAGE. ALTERATIONS IN THIS SECTION ARE NOT ALLOWED:

In block 17, select one health plan and one level of coverage or check "Refuse." If you refuse health coverage or fail to enroll yourself and all eligible dependents within 31 days of eligibility, you can apply for coverage for yourself and/or your dependent(s) only during an open enrollment period (every two years). Changes from one health plan to another are allowed only during designated enrollment periods (exceptions: changes due to eligibility for Medicare; and if HMO enrollees move out of the service area). The Savings Plan is available only to non-Medicare enrollees and dependents.

In block 18, indicate level of dental coverage or "Refuse." If you refuse dental coverage or fail to enroll yourself and all eligible dependents within 31 days of eligibility, you can apply for coverage for yourself and/or your dependents only during an announced open enrollment period (every two years).

In block 19, indicate Dental Plus ("Yes" to enroll or "Refuse"). You must enroll in the State Dental Plan to enroll in Dental Plus. You must also cover the same family members under both plans.

MEDICARE AND OTHER COVERAGE AND/OR PART B: In **block 20**, list yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

In block 21, if you checked "Yes," list all dependents with other group coverage. If you are submitting an update because a dependent no longer has other group health coverage, check "No" and list the termination date of the policy.

DEPENDENTS: In **block 22**, list all children to be covered under health and/or dental. If they are not listed, they will not be covered. Legal documentation is required for all children other than natural children (i.e. grandchild, niece, nephew, foster child, brother, sister or adopted child). For a child age 19 through 24 to be considered eligible for coverage, the dependent must be a full-time student or incapacitated. (Documentation required for both.) Full-time student status is subject to audits. Misstatements on the NOE may result in coverage termination and recoupment of benefits paid on behalf of the ineligible dependent.

CERTIFICATION AND AUTHORIZATION: Read **block 23** carefully, sign and date form.

Send the original form to the Employee Insurance Program, P.O. Box 11661, Columbia, SC 29211. Keep a copy for your records.